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Addressing Cultural Competence in the Health Care Setting: An Introduction

By

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In the past decade, over twelve million immigrants entered the United States. This pattern exceeded the last previous wave of immigrants between the years 1905 and 1914 (Lester, 1998). Formerly, the U.S. was characterized as a melting pot, where individuals from various countries and cultures merged to form a new and homogenous society. This characterization no longer exists and has been replaced with a pluralistic view, whereby persons maintain their separate identifies, while contributing to the whole composition (Hansen, 1992, p. 17.). United States, already a diverse society, is increasingly becoming multicultural and multilingual. Federal agencies now mandate that health care institutions meet criteria for providing culturally competent care.

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Cultural competence is defined as a way of thinking and behavior, and is a process of framing assumptions, knowledge, and meanings from a culture different than our own (Bartol & Richardson, 1998, p. 75). Achieving cultural competence begins with examining one's own culture and how our culture affects our behavior and belief systems. Cultural congruence implies maintaining an open and inquiring attitude towards the cultural beliefs and behaviors of others (Bartol & Richardson, 1998). Cultural competence does not mean that every health care provider should know everything about a patient's culture in order to be competent, but rather that a health care provider possesses the ability to develop working relationships across lines of differences (Lester, 1998). It is important to note that cultural competence is relevant to all aspects of difference: gender, race, age, sexual orientation, religion, and socioeconomic class (Lester, 1998).

Chan (1990) cites three critical elements in the development of cross-cultural competence: self-awareness, knowledge of specific cultural group information, and skills to enable an individual to engage in successful interaction. Conveying respect, a sense of mutuality, and humor can largely facilitate an effective interaction process between health care providers and individuals and families of diverse backgrounds seeking health care. The following articles present cultural aspects in cancer care.

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The Influence of Culture on Information Seeking Behavior

by

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Educating patients is one of the most important functions of nursing care today, yet how do nurses determine how much information to give to patients? Understanding a patient's information seeking behavior can assist nurses when applying nursing interventions, which can ultimately lead to positive cognitive and behavioral outcomes. Lack of information can cause anxiety, decisional conflicts, ineffective coping, decreased control, and powerlessness (Lenz, 1984). Research has found that information should be provided based on one's information seeking behavior, a type of coping style (Miller, 1995; Morgan, Roufeil, Kaushik, & Bassett, 1998). For these reasons, it is vital to assess the information seeking behaviors of individuals undergoing cancer treatment before stimulating them to search or before providing information to them.

When patients are diagnosed with cancer, treatment plans are individualized based on specific characteristics of the particular cancer. Parallel to this concept, patient education should be provided based on patient characteristics. According to Miller (1995), patients do best when information is matched with their information seeking behavior; information seekers should receive more information and information avoiders should receive less information. Identifying the predictors of information seeking behavior may assist with determining who is an information seeker and who is an information avoider. Learning more about a patient's profile will allow educational interventions to be rendered in an evidence-based manner. In essence, targeted patient education would be based upon specific predictors of information seeking behavior.

Information seeking behavior has been studied in various groups, such as students, doctors,

nurses, and patients. This concept is defined as actions, activities, and attempts used to obtain, validate, clarify, or increase knowledge, which includes asking questions, initiating discussions, or other nonverbal behavior (Baker & Connor, 1984; Barsevick & Johnson, 1990; Beisecker & Beisecker, 1990; Corbo-Richert, Caty, & Barnes, 1993). Hopkins (1986) and Lenz (1984) both agree that information seeking behavior is a coping strategy where the patient is the active seeker and the behavior is a component of patient decisions (Lenz, 1984).

Lenz's (1984) theoretical framework of health information seeking, adapted from a consumer perspective, was one of the first models using patients as the information seekers. Search behavior can vary for a number of reasons. According to Lenz's conceptual framework, three variables that are potential predictors of a variation in search behaviors are background, personality, and context. Background includes sociodemographic characteristics such as age, socioeconomic status, marital status, employment status, ethnicity, sex, and previous experiences. In addition, she theorizes that the conditions under which search behavior is performed may also foretell differences. "Search is conceptualized as an interpersonal process, with the primary sources of information being others to whom one has direct access or can be referred" (Lenz, 1984, p. 61). She suggests that "persons of a social network have different information" (p. 61).

Culture refers to "the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular group that guide their thinking, decisions, and actions in patterned ways" (Leininger, 1995, p.9). In essence, cultural is contextual. Lenz (1994) proposes that contextual variables will influence search behaviors. Parallel to this concept, Leininger (1995) explains that client behaviors are

influenced by cultural factors. Perceptions and experiences of health and illness are affected by culture. Social networks influence behaviors, beliefs, and decisions about health and illness. Ethnicity is referred to as shared origins and culture (Loustaunau & Sobo, 1997). Therefore, ethnicity formulates a cultural/social network. All of these concepts are congruent to Lenz's model of information seeking behavior.

Cultural perspectives that determine attitudes toward illness and treatment may affect information-seeking behavior among diverse cultural populations. Many cultures believe in fatalism or God's will. This may ultimately affect the process of information seeking behavior. United States' trends indicate that ethnic minority populations are growing at rates that surpass the rest of the population's. Consequently, in the future, they will represent the majority and not the minority.

One of the few studies that integrated ethnicity with the examination of information seeking behavior as a coping style involved a sample of minority low-income women ($n = 36$) undergoing follow-up examination for abnormal cytological smears. Coping mechanisms in relation to information seeking behavior were measured using the Miller Behavioral Style Scale (Miller, 1987). Findings revealed that although subjects sought information, the degree of seeking varied from moderate to excessive (Miller, Roussi, Altman, Helm, & Steinberg, 1994). Although this study used the term minority, it should be noted that minority status refers to lack of opportunity, access, and participation (Loustaunau & Sobo, 1997). Furthermore, the ethnic background of the minorities was not described in the study. Therefore, questions remain regarding the ethnic background of subjects in this research.

Hopkins' (1986) correlational study examined information seeking and adaptational outcomes in women receiving chemotherapy for breast cancer (n= 58). An ANOVA revealed no significant differences in the information seeking behavior between white and non-white participants. However, these findings should be viewed with caution as eighty-four percent of the subjects were white; therefore little diversity was represented.

It is essential to understand attitudes and values of diverse cultures when providing patients with information regarding their health care. According to Lenz's theory of information seeking, certain ethnic groups will have different search patterns and the information obtained may be dissimilar as compared to other ethnic groups. A dearth in the literature exists about cancer patients of different cultures and their information seeking behavior. Future research should investigate culture and its relationship to information seeking. Studies are needed to clarify the relationship of one's cultural/ethnic origin, a potentially significant variable, and information seeking behavior.

Cancer patients are faced with not only a life threatening disease, but also a disease that will ultimately change their lives. Because of the diagnosis of cancer and its treatment, it is imperative for patients to know and understand not only about the disease and therapies, but also about the physical, psychological, and social impact cancer will have on their world. Collecting data about the information seeking behavior of cancer patients will assist in the development of tailored patient education. Future research should examine factors (such as culture) that influence information seeking behavior of cancer patients.

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Culturally Congruent End-Of-Life Care For Jewish Patients And Their Families

by

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The Center for Hospice Care is a nonprofit organization serving the northern part of New Jersey and a large Jewish community of more than 249,000 people. As part of a grant from the Health Care Foundation of New Jersey, a qualitative study was conducted to determine cultural influences in end-of-life care meanings among Jewish patients and their families. Findings of this study were used to create a program for Jewish patients and their families on end of life issues, and to promote staff awareness of Jewish values, beliefs, and practices that influence end-of-life care.

Review of the Literature

A review of the literature identified that Jewish people are linked together by a common history, ethical teachings, common rituals, language of prayer, folkways, and a sense of common destiny (Schwartz, 1995). The ethnohistory of the Jewish people reflects many struggles to survive, grow, and maintain their cultural identity and place in the world (Leininger, 1995).

The foundations of the Jewish culture are family closeness, unity and the stability of the family, which are regulated to some extent by the Jewish religious laws and values (Leininger, 1995). The concept of family reflects in the Book of Genesis, in that the entire human race is a collection of separate families who are nonetheless related to one another (Jacobs, 1984). Jewish culture stresses that solidarity among kin is fundamental to humans, and particularly to Jewish tradition.

A common predominant view that binds Jews with their heritage is that one suffers because of what the world does to you. Suffering is even a form of sharing with one's fellow Jews (McGoldrick, Pearce, & Giordano, 1982). Jews have historically suffered from persecution creating an underlying assumption that suffering is a part of life. Expressions of grief are not viewed as a sign of weakness, but as a deep psychological need that all persons possess (Bale, Lamm, & Samson, 1988). This tradition recognizes that the pain of watching a family member die can cause grief reactions in caregivers and the community as well.

In Judaism, life is valued, almost above all else. The Talmud notes that all people are descended from a single person; thus taking a life is akin to destroying an entire world, and saving a life is representative of saving an entire world (Jacobs, 1984; Leininger, 1995). Judaism views that humans are created in God's image and is a gift from God. Jewish medical ethics dictate the imperative that preservation of life supercedes quality of life considerations. This is contrary to the American value that takes quality of life as a primary consideration in making end of life decisions (Ross, 1998; Selekman, 1998). Jews also believe that illness is not a coincidence. It may be viewed as a beneficial event caused by a Divine message for human reflection and soul searching to improve oneself and express regret (Selekman, 1998).

Theoretical Framework

The theoretical framework used in this study was Leininger's Culture Care Theory (1995). Leininger's Culture Care theory aims to discover human care diversity and universality in order to generate new knowledge in which to guide nursing practice. This is achieved by identifying differences between the emic, or professional perspective, and the etic, or folk systems. The professional knowledge of the nurse may not reflect culturally based knowledge that largely guides human decisions and actions. The model postulates that different cultural forces influence care, which, in turn affects the health and well being of people (Leininger, 1995).

Methodology

An inductive, qualitative design was chosen for this study, using interviews to draw out participants' ideas and perceptions that could define core themes relevant to end of life issues. An interview guide was developed using open-ended and focused questions. Participants were interviewed for at least 30 minutes at their work settings (nursing home or hospice) or at home by telephone. Responses were recorded in writing by each interviewer.

A purposive, convenience sample was utilized. Participants consisted of 16 adults, who volunteered for the interview. All participants had experience with hospice care as a professional caregiver or family member. The 11 professional caregiver participants worked at the hospice center or at a nursing home affiliated with the center. This group included 3 rabbi directors of hospice and pastoral care; therefore, this group consisted of experts in Jewish beliefs/values and end of life care. The remainders of the professional caregiver participants were experts in hospice care and had experience and expertise in providing end of life care to the Jewish population. The remaining group

represented 5 Jewish family caregiver participants who had used hospice services in the past. Demographic data included age, gender, religious affiliation (sect of Judaism), occupation, and experiences with hospice care as a family member, primary caregiver or staff.

Findings

Data was analyzed individually and in aggregates for recurrent patterns from which caring themes relevant to end of life care were derived. Data was also analyzed for intragroup and intergroup (professional versus non-professional; Jew versus non-Jew) commonalities and differences. Seven thematic findings are presented using sample statements from informants whose names have been changed to protect their anonymity, in addition to an integration of knowledge from the literature, in order to provide support, or contrast to, the study findings.

Caring is a Communal Duty and Obligation for the Sick and Dying, Requiring Physical Presence.

One rabbi informant said, "*Many of the Jewish laws are connected with caring for the ill. There is a Jewish commandment to take care of people who are less self-sufficient and in more need than you are, for example, the dying*". According to Belitsky (1985), terminally ill patients suffer deeply from fear of abandonment because during the final days and weeks of their life, when they need most to feel connected to the world, the world withdraws. Judaism prevents isolation of the dying person through the mitzvah of *bikur cholim*, which is the commandment to visit the sick.

Caring Promotes Holistic Comfort by Addressing Physical, Emotional, and Spiritual Needs.

Donna, a 42-year-old Conservative Jew, mother of three small children who had converted to Judaism in order to marry, related her experiences of caring for her terminally ill husband at home. She

defines caring according to the Jewish faith as, *“The Jewish community comes together as a family and provides whatever is necessary to support the family. I could never have made it without the help of the Jewish community”*.

Caring is Compassionate and Unconditional Giving for the Purpose of Improving or Enhancing the Life of Another.

A Jewish hospice staff member stated that caring means, *“the giving of oneself to improve or enhance the life of another”*. Another hospice staff member stated, *“The concept of hospice focuses on improving the quality of life”*. In the Jewish tradition, benevolent acts include visiting the sick and offering words of encouragement and praise, thereby, acknowledging the patient’s self worth (Jacobs, 1984).

The Value Placed on Knowledge is Expected and Integrated in the Care of the Dying

This worldview was validated by a professional caregiver and one rabbi who stated, *“There is a strong respect for the medical profession. If the MD presents a treatment option, they (the Jewish population) will go along with it”*. In contrast, a family member who was a Reformed Jew stated, *“The physician gives the information and the patient makes his own decision”*. Another rabbi stated, *“Knowledge equals value. Knowledge brings you closer to God. Education and knowledge make the expert”*. This expert, as defined by the Jewish individual or family is the person sought out for guidance.

Belief in Afterlife Influences Attitudes Toward Suffering Associated With Dying.

Leslie, a non-Jewish hospice social worker, observed the ambiguity in the Jewish concept of the afterlife. In her practice among Reform Jews, she identified a group that tended to be irreligious. They stated, *“they have a fear of death because they lack*

a clear-cut view of an afterlife”. One Orthodox Rabbi informant related a story of an elderly woman whose husband was dying. After consulting with him, the woman was able to say to her husband, *“It’s time to go, George; it’s time to go to the other side”*. After she said that, George took his last breath and died. The wife later told the rabbi that by saying these words, she felt at peace and believed that he would also finally be at peace.

Religious and Cultural Factors Highly Influence Hospice Care and Bereavement Practices.

A family caregiver informant stated, *“I do not believe in hospice care. Even if they are kept alive on machines, they are still alive”*. In contrast, another family informant expressed satisfaction with the care. *“Hospice was a beautiful experience; hospice allowed my father to die peacefully at home”*. Due to their history of persecution for religious beliefs and practices, the Jewish community is more comfortable in a bereavement group of their peers (Leininger, 1995).

Sense of Community is also reflected in the communal expression of pain and suffering

Communal suffering has been linked with the long experience of persecution by the Jews throughout history, which created a worldview that suffering is a part of life. Feelings of persecution and suffering are part of a cultural heritage assumed with pride and expressed as a form of sharing with one’s fellow Jew (McColdrick et al., 1982).

Conclusions

Findings revealed both common and diverse themes between professional staff and family members, as well as differences among Jewish informants themselves. A significant difference was the continuity between community and family in caring for the terminally ill members, expressed by family caregiver informants. Such a value was not part of the holistic care shared by professional staff

members. Family caregiver participants viewed the Jewish community as a family and expected them to conduct themselves as a part of a cohesive family. In contrast, professional staff members viewed caring as the responsibility of the patient and family, not the community. Although the professional staff members identified the value of holistic care, this concept was generally limited to the patient and family as a group, not the community.

Hence, findings of this study revealed differences and similarities in two levels: between professional and folkways of caring and among the Jewish families themselves. End of life care demands that professional caregivers restructure their care to preserve and accommodate those values and beliefs that strengthen the meaning of life and death for individuals and families. Professional actions and decisions that are facilitative, enabling, and supportive require a specific cultural knowledge base and the ability to address the unique life contexts of patients and families (Leininger, 1991).

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Cancer Care of Hispanic/Latino Patients

by

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The number of Hispanic and Latino (H/L) citizens in the United States is rapidly growing, and increasing faster than any other ethnic group within the United States (Murillo-Rohde, 2001). It is estimated that by 2005, the H/L group will represent the largest group, made up of many ethnic groups, within North America (Andrews & Boyle, 1999).

The H/L population is made up of a diverse group of people, including Mexican-Americans, Puerto Ricans, Cubans, as well as those from Central America, South America, and Mexico. It is up to the health care provider to learn about each patient's ethnicity, keeping in mind that the patient may have a preference for either the term Hispanic or Latino. Or, the patient may prefer to be referred to more specifically, such as Dominican. The best way to know how the patient refers to his or her ethnicity is to ask the individual in a respectful manner (Cavilla & Flaskerud, 1997).

The incidence of cancer among the H/L population indicates that cancer of the colon, breast, prostate and lung are among the most frequent diagnoses. The number of H/L woman with cervical cancer is second only to Vietnamese woman. H/L

are also at risk for stomach cancer, gallbladder and liver cancers. Hispanic/Latina women are twice as likely as White American women to develop cervical cancer, which may be due in part to reluctance to have examinations, Pap smears, or other screening tests (Murillo-Rohde, 2001).

Initiatives to generate interest in screening and early detection include community health fairs or educational materials printed in Spanish. Care must be taken with translations to provide materials that are appropriate for the specific group in the community. There are many different dialogues of Spanish and there is no one dialogue that is appropriate for all H/L patients.

Like all other individuals, patients who are H/L have special cultural needs. The diverse culture and ethnicity demand understanding in order to begin to provide culturally competent care for each H/L patient. In addition to providing access to care and recruiting efforts to screen this culturally diverse group, translation services may be needed, as well as a special understanding of traditional roles and importance of family.

Below are some areas, and possible H/L influence, that need to be considered by the health care providers when planning and communicating with a patient who is H/L. Please keep in mind that these are broad statements that are meant to provide an overview; but, which must be explored and tailored for each patient. Factors which may influence the health care practices of any individual include age, education, socioeconomic status, language fluency, and level of acculturation or assimilation (Cavillo & Flaskerud, 1997; Spector, 1996). Acculturation refers to the changes made to be accepted into the host society, while assimilation allows persons to maintain language, traditions and values (Palos, 1998).

Considerations in Caring for a Patient who is Hispanic/Latino

Family – The family plays an important role and extended family may want to be at the bedside. Family members may make decisions for the patient and in some cases a diagnosis of cancer may be kept from the patient. Within the family, male and females have distinct roles. Many decisions are made by the males, but many health care decisions may be made by the female (Murillo-Rohde, 2001).

Education – H/L have strong family ties and informal information is shared within the family and community. Respect is a valued trait and must be kept in mind through all communications. When teaching the H/L patient about treatment, it is important to realize that language barriers for anatomical terminology may exist, in a patient or family member that is otherwise fluent in English. Reluctance to hold a conversation or ask questions in the presence of a translator must be carefully assessed prior to any discussion. Discussions between a health care provider and a patient of a different gender may cause embarrassment. The likelihood of this must be considered prior to having a conversation that might be embarrassing for the patient.

Religion – H/L patients may find comfort in prayer or rely on prayer or spiritual rituals for healing. Spirituality may be combined with traditional medicine.

Psychological – Patients may view illness as punishment, or be fatalistic about the outcome.

Sexuality – Illnesses associated with reproduction organs may cause fear, and result in a lack of communication of symptoms, or refusal of surgical or medical treatment. The family or fear of weakening a traditional role (i.e. husband, wife) may be influential in the patient's acceptance or

denial of treatment. Patients may be reluctant to have routine examinations of reproductive organs (e.g. Pap smears, PSA testing of prostate cancer), due to modesty, or because reproductive organs are associated with sexuality.

Health care practices – Healing practices may precede or occur in conjunction with medical treatment, including relief of pain. Healing practices may include consultations with: the Curandero (use of herbs, diet, message and rituals), spiritualist (analyze dreams and foretell future), or Sabador (message and manipulation of bones and muscles) because physical touch and herbs promote healing (Murillo-Rohde, 2001).

Food – H/L use cold and hot foods to promote health and rid the body of illness. This is very important when administering oral medications and for patient teaching after discharge. The patient and family may believe that the medicine will only work when taken with a specific beverage (hot or cold). It is important to allow each patient to preserve their belief (Andrews & Boyle, 1999), while assuring that an acceptable combination is communicated so the patient takes the medicine with a beverage that is compatible with specific medication.

It is essential when caring for all patients to consider each patient as an individual, with distinct attitudes, behaviors and beliefs influenced by culture and ethnicity. The likes, dislikes, adjustment and coping patterns are unique to each individual, and must be explored after establishing trust, respect, and confidence with patients and family members (Palos, 1998). Learning about different cultures provides health care professionals with general information; however, specific information about the patient and family must be incorporated into an individual plan of cancer care. Providing culturally competent health care to each patient

requires knowledge, understanding, acceptance and respect for diverse cultures.

For more information about care of the Hispanic/Latino patient see the following resources:

National Cancer Institute

800-4-CANCER

<http://cis.nci.nih.gov/>

Provides information about cancer and treatment in both Spanish and English.

American Cancer Society

340 Peachtree Road, NE

Atlanta, GA 30046

800-227-2345

Hispanic Health Council

175 Main Street

Hartford, CT 06106

860-527-0856

National Minority Health Association

PO 11876

Harrisburg, PA 17108-1876

717-234-3254

National MultiCultural Institute

3000 Connecticut Avenue NW, Suite 438

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202-483-0700

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